Alabama Department of Senior Services Medicaid Waiver Programs

Case Management Home Visit Tool

(Client Assessment)

Name of Client	Medicaid Number	Name of Case Manager	Date

Present During Home Visit:

☐ Primary Caregiver ☐ Service Provider/HA ☐ Family/Friend ☐ Other ☐ None

Caregiver System is:

☐ Supportive ☐ Strained ☐ Adequate ☐ Inadequate ☐ Other

Type of Visit

☐ Monthly ☐ Recertification/Redetermination ☐ Reinstatement ☐ Other

Health and Safety (client)

Client's physical status is acceptable (no bruises)?	☐ Yes ☐ No ☐ NA	Comments:
Client is clean?	☐ Yes ☐ No ☐ NA	
Client is free of odor?	☐ Yes ☐ No ☐ NA	
Client is properly groomed?	☐ Yes ☐ No ☐ NA	
Client is dressed appropriately?	☐ Yes ☐ No ☐ NA	
Client's nutritional status is acceptable?	☐ Yes ☐ No ☐ NA	
Client's mental status is acceptable?	☐ Yes ☐ No ☐ NA	Comments:
Client is alert?	☐ Yes ☐ No ☐ NA	
Client is oriented?	☐ Yes ☐ No ☐ NA	
Client is confused?	☐ Yes ☐ No ☐ NA	
Client exhibits memory impairment?	☐ Yes ☐ No ☐ NA	
Client is hallucinating?	☐ Yes ☐ No ☐ NA	
Client's Gait is:		Comments:
Steady without help?	☐ Yes ☐ No ☐ NA	
Steady with use of assistive device?	☐ Yes ☐ No ☐ NA	
Client needs device/does not have?	☐ Yes ☐ No ☐ NA	
Client has device/does not use?	☐ Yes ☐ No ☐ NA	
Client's assistive devices are in good working order? (walker, wheelchair, cane, trapeze bar, etc.)	☐ Yes ☐ No ☐ NA	
Client reports falling since last visit?	☐ Yes ☐ No ☐ NA	
IRS report filed?	☐ Yes ☐ No ☐ NA	

Additional comments on client condition…i.e. what client is wearing, doing & who is present etc:

Health and Safety (home)

Home Environment is:		Comments:
Clean?	☐ Yes ☐ No ☐ NA	
Safe? (trip/fall/fire hazards)	☐ Yes ☐ No ☐ NA	
Uncluttered?	☐ Yes ☐ No ☐ NA	
Odor free?	☐ Yes ☐ No ☐ NA	
Structurally sound?	☐ Yes ☐ No ☐ NA	
Home has working utilities?	☐ Yes ☐ No ☐ NA	
Refrigerator/freezer is free of expired food?	☐ Yes ☐ No ☐ NA	
Premises are free of infestation?	☐ Yes ☐ No ☐ NA	
Client's adaptive devices are in good working order? (ramps, grab bars, etc.)	☐ Yes ☐ No ☐ NA	

Additional comments on home condition…i.e. condition of home, rooms inspected, hazards noticed? List adaptive devices:

Provision of Services

Client/caregiver is satisfied with the services received?	☐ Yes ☐ No ☐ NA	Comments:
Amount and type of service(s) provided is/are appropriate to meet client needs?	☐ Yes ☐ No ☐ NA	
Are there any unmet needs which haven't been addressed? (If yes explain in comments.)	☐ Yes ☐ No ☐ NA	
Client/caregiver was afforded "Freedom of Choice"?	☐ Yes ☐ No ☐ NA	
Client/caregiver is comfortable with the service provider and does not want to make a change?	☐ Yes ☐ No ☐ NA	
Excess home delivered meals? How many meals in freezer?	☐ Yes ☐ No ☐ NA	
Home delivered meals are utilized properly?	☐ Yes ☐ No ☐ NA	
There is an assessable file in the home with the following (current & signed as required) forms:		Comments:
1. Service Provider Authorization	☐ Yes ☐ No ☐ NA	
2. Care Plan	☐ Yes ☐ No ☐ NA	
3. Case Review & Fair Hearing Instructions	☐ Yes ☐ No ☐ NA	
4. Client Rights & Responsibilities	☐ Yes ☐ No ☐ NA	
5. Complaint/Grievance Policy & Procedures	☐ Yes ☐ No ☐ NA	
6. Contact info for CM/DSP/ADSS/AMA in folder?	☐ Yes ☐ No ☐ NA	

Additional comments on service provision…i.e. list all waiver & non-waiver services & their frequency:


Health Education		
Client/caregiver uses specialized equipment (oxygen, blood glucose monitor, nebulizer, etc) and it is functional?	☐ Yes ☐ No ☐ NA	Comments:
Client/caregiver knows how to use the specialized equipment and uses it properly?	☐ Yes ☐ No ☐ NA	
Client/caregiver has received new (un-reported to the case manager) special dietary instructions?	☐ Yes ☐ No ☐ NA	
Client was hospitalized since last visit?	☐ Yes ☐ No ☐ NA	
Client saw the physician since last CM visit?	☐ Yes ☐ No ☐ NA	
Any changes to client's medications?	☐ Yes ☐ No ☐ NA	
Additional comments on health education…i.e. list most recent medical appointments & specific changes to meds:		

Medicaid Eligibility		
Client reports receiving letters/phone calls from AMA about their eligibility?	☐ Yes ☐ No ☐ NA	Comments:
Client reports receiving letters/phone calls from Social Security about losing benefits?	☐ Yes ☐ No ☐ NA	
Additional comments on Medicaid eligibility…i.e. note any/all other correspondence reported by client:		

Case Manager Information		
Client/caregiver knows to discuss with\call the CM if there is a concern/problem with services?	☐ Yes ☐ No ☐ NA	Comments:
The CM provided the client with his/her telephone number & with Medicaid's toll free telephone number?	☐ Yes ☐ No ☐ NA	
The CM discussed "Benefits & Outcomes" of each service with the Client/caregiver?	☐ Yes ☐ No ☐ NA	
The CM informed the Client/caregiver of other available sources of support as needed? (travel vouchers, other agencies/services…etc)	☐ Yes ☐ No ☐ NA	
The CM discussed the NET Program with Client/caregiver?	☐ Yes ☐ No ☐ NA	
Additional comments:		

(The below may be used in place of the *MW-11 Case Management Verification* form)

Case Management Verification

This is to certify that the below information is true, accurate and complete. I understand that by signing this form, I am certifying to the Alabama Medicaid Agency that I received Case Management services on the date reflected below.

_____ _____

Client/Caregiver Signature Date Signed